Journal
of the
Child Welfare League
of America
Inc.

child welfare

March 1960

CHILD WELFARE

JOURNAL OF THE
CHILD WELFARE LEAGUE OF AMERICA, Inc.

HENRIETTA L. GORDON, Editor

CHILD WELFARE is a forum for discussion in print of child welfare problems and the programs and skills needed to solve them. Endorsement does not necessarily go with the printing of opinions expressed over a signature.

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Editorial and general office: 345 E. 46th Street, N.Y. 17, N.Y.
Published monthly except August and September by the Child Welfare League of America, Inc.
Annual Subscription, $4.00
3-Year Subscription, $10.00
Individual Copies, 45 cents
Student Rates—Annual Subscription, $2.75
2-Year Student Subscription, $5.00

Library of Congress Catalog Card Number: 52-4649

VOL. XXXIX No. 3

SOCIAL WORK POLICIES, SERVICES AND SUPPORTING VALUES

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A discussion of Social Welfare Policy and Services in Social Work Education, *by Irving Weissman (94 pages, $2.75) and* The Teaching of Values and Ethics in Social Work Education, *by Muriel W. Pumphrey (164 pages, $3.75). This review of volumes XII and XIII of the thirteen-volume curriculum study published under the auspices of the Council on Social Work Education is being presented in the form of an article because of the special importance of the curriculum study to the field.*

SPOKESMEN for the so-called "Beat Generation" profess to be unconcerned about seeking or debating answers because they know not what the question is. There is, at least, an honesty to this. In our world there are so many, offering answers prolifically and prolixly, who give too little thought to identifying the cardinal questions. Significant answers presuppose the posing of the significant questions.

The group of thirteen who, under the leadership of Werner Boehm, were responsible for the Curriculum Study of the Council on Social Work Education, endeavored to establish the objectives to be sought in the curriculum for the education of social workers, and to suggest appropriate means for their attainment. They immediately identified the question fundamental to this task: What is the nature of social work? It is a question which the social work profession had long evaded, sometimes seeming to say that it could not be answered, sometimes saying it was not wise to answer it, and sometimes dismissing the question as a relatively unimportant exercise in semantics. The study staff propose an answer, based on their understanding of what social workers are actually doing that is specific to them, different from what related professions are doing, and different from the contribution made to social well-being by citizens from any and every walk of life. The answer they give will, undoubtedly, provoke controversy, but the question has been put and disputants must also answer it.

The goal of social work is defined in the study as the enhancement of the social functioning of individuals, singly and in groups. It defines the problems with which social work deals as those which arise out of the *interaction* of man and his social environment. To this goal and to these problems social work applies a method which, in its core element, is the controlled and disciplined use of a helping relationship with persons. Others may use a similar method, but they use it to further a different goal and with a different problem focus. Still others may seek the same goal and be concerned with similar problems, but they use a different method.

It would seem that objection to the problem focus as the interaction of man and his environment will come from two sources: from those who would put social work's emphasis on problems arising within man himself, and from those who would put the emphasis on problems arising in man's environment. In the first group are those who have tended to see social work mainly as an individual psychotherapy, a focus which often obscured any functional differentiation from psychiatry and clinical psychology, and came near to losing for us our professional identity. In the second group are those who have been concerned about some of the things that social work is not doing and

constantly chide us because we are not changing man's environment. Reacting against an overly individual-centered social work, they would have us assume a more global view and focus on social reform and social change.

Social Welfare Policy and Services

Irving Weissman's study of educational objectives in that part of the curriculum known as the social services sequence[1] seems to have been made in the context of this latter view of social work, or at least to have been greatly influenced by it. Although Weissman refers to the total study's statement on the nature of social work as being the "screening instrument" for all projects, it is difficult to see its use in this particular project, and to identify what has thereby been screened out. The change of title for this content area which Professor Weissman recommends, from "the social services" to "social welfare policy and services," is quite indicative of the broad focus he would have us take. The vast range of content he suggests would seem to require the whole two-year curriculum if it is to be treated at any significant depth, a difficulty which is far from overcome by the intrusion of social work education into the senior and junior years of liberal arts education, as proposed in the study.

Weissman recognizes, as we all must, the vagueness and variance in common usage of the terms "social welfare," "the social services," and "social work." To provide what he calls "an anchoring term of reference," he defines social welfare in the institutional sense as a related system of social institutions in a society unified by common values, goals and operational principles. He accepts the term "the social services" as a synonym for social welfare programs, a usage originating in the United Kingdom and quite widely current today.

The further term of reference that is required is "social work" as defined in the Curriculum Study as a whole. It is the relationship of social work to social welfare which must provide the guide to what the social worker *as social worker* should know about this content area. Weissman does not make this relationship clear and, as a consequence, the focus on social welfare is not sharp enough to illumine whatever has social work relevance. He recognizes part of this difficulty and the problems created by having to deal with the "vast, varied, and voluminous material" pertinent to social welfare. He tries to solve the difficulty by proposing that this material be dealt with at "a high level of abstraction," which he calls applying "the principle of professional relevance." But this is to refine and condense in a general professional sense, equally significant or equally vague for all the professions that contribute to social welfare. What is needed is a reduction relevant to social work. The alternative is to disavow the concept of social work that underlies the whole Curriculum Study, and to claim all the purlieus of social welfare for social work.

A social work relevance for the study of social welfare in the social work curriculum can be facilitated if one defines "the social services" more clearly and precisely. A service implies some kind of personal relationship between the server and the served. Within the ambit of social welfare there are many programs which do not inherently require such a relationship, and some which definitely exclude it: e.g., family allowances, Old Age and Survivors' Insurance, unemployment insurance. It is surely a distortion of meaning to classify these as social *services*, notwithstanding the precedent set by Beveridge and the benediction bestowed by Titmuss.

There are other social welfare programs in which a personal relationship is of the very essence: e.g., the child welfare services, family casework, group work services. These are the social services, and it is not by accident that ordinary social work usage has labeled most of them "services." In these, social work, with its relationship method, has found

[1] Irving Weissman, *Social Welfare Policy and Services in Social Work Education*, Vol. XII, A Project Report of the Curriculum Study, Council on Social Work Education, N.Y., 1959.

its area of pertinence within the general framework of social welfare. Instead of trying to cover, at any level of abstraction, the wide compass of social welfare, it would seem more fitting to limit curriculum coverage to those services which use or can use the unique contribution of social work—the social services. This can be done in an intensive way, and it offers greater promise of aiding the emergence of "social statesmen" who are social workers than does a curriculum sequence that inevitably can achieve extension only at the cost of intension.

Weissman's point of departure has been questioned, but the lucid and thoughtful way in which he goes on to develop objectives in the social services sequence commands high respect. Cogently and concisely, within the short compass of eighty pages, he sets forth a logical and consistent basis of progression which should lay the last lingering ghost of the old descriptive courses. Essentially, it would require that the student sequentially understand the problem to be dealt with, the policy that should govern the quest for solution, and finally the provisions that actualize the policy and meet the problem. These "core concepts" must be understood within the context of scientific validity, social purpose, and professional goals. They must be subjected to analysis in terms of the rights of persons, the responsibilities of society, the capabilities of the group, the community and society, and the roles of different professions and persons. This framework of objectives certainly has educational *and practice* purpose and significance.

The social worker in child welfare who can recognize the general problems that manifest need, and in so doing distinguish fact from opinion; who can weigh all the factors, the rights and responsibilities, the individual and social values, that must enter into the formulation of a remedial policy; who can then translate that policy into concrete provisions based on what can be done with the social forces available; and finally who can distinguish appropriately the pertinent contribution to the service by various disciplines, including social work, is the exception rather than the rule. But such capacities are desirable not only for the social worker formally engaged in planning, but also for all responsible practitioners, who ought constantly to scrutinize the problems with which they deal, the policy of which they are an instrument, and the service they help administer. The goal may be set high but gain must accrue from the striving to reach it.

The Teaching of Values and Ethics

The type of approach suggested involves us quite directly in value judgments. To identify a social problem one must make a value judgment, either explicitly or implicitly. Policy immediately involves us in judgments about individual values and the common good, a value in itself. It is surprising that the formal treatment of values, particularly values that are almost an integral part of social work, has not been generally accepted as having a specific place in the curriculum. Muriel Pumphrey's report on values and ethics[2] brings together a mass of evidence pointing to the desirability of treating values in the curriculum, and suggests minimal content that should be included. Her report is quite comprehensive, particularly when we consider how little this subject had hitherto been developed. But it is in no way ponderous.

Social work has long been plagued by a quasi-neutralist façade which often made taboo any formal discussion of values, particularly those that might be highly controversial. Many factors entered into this. Among them were a confusion about the principle of self-determination, which led to consideration of values and ethical decisions as wholly a matter of individual choice, and a reluctance to take a firm position in the face of conflicting values and value systems. Sometimes this attitude seemed to be related to a pseudo-scientific pose, actually quite unscientific, since any applied science must con-

[2] Muriel W. Pumphrey, *The Teaching of Values and Ethics in Social Work Education*, Vol. XIII, A Project Report of the Curriculum Study, Council on Social Work Education, N. Y., 1959.

stantly make value judgments, and even pure science cannot evade fundamental ones. Despite this, values were being taught, directly or indirectly; and value judgments permeated social work practice, entering into the decision that something ought to be done, and into the choice of what should be done and how it should be done. Mrs. Pumphrey gives an interesting example of one of many methods classes which she audited during the project, in which she tabulated forty-six explicit and twenty-one implicit value statements by the instructor, only to be greeted at the close of the class with an apology for "having touched on no values at all."

A strong case is made for formal and progressive instruction in values and ethics, rather than leaving the treatment of these to accidental, or even planned, development in other courses. It is pointed out that this can lead to "fragmentation, unequal emphasis and an over-intensive impression of conflicting values and uncertainties." Students frequently express the need to be given some steady frame of reference to use in considering values. Mrs. Pumphrey believes that one reason schools may have been slow to attempt this was that there was no explicit demand for it from the employing agencies. This is contrary to the present writer's experience. At the Canadian Conference on Social Work Education in 1956, it was the practice and agency group which insisted on the need for a philosophy sequence which would provide a value orientation for future practitioners.

One area of particular need is exploration of the philosophy of individual freedom and the common good, and the value implications in this. Mrs. Pumphrey found that there was keen recognition of this among group workers and group work teachers who were always being confronted with very patent applications of it, but it should be of similar importance in all social work methods. Too often this very complex question is dismissed as if the good of society and the sum total of the good of the individuals in it were one and the same thing. Nor are students satisfied when questions are answered by, "It all depends on the circumstances," and their dissatisfaction is justified. The search for understanding takes one, however, into quite profound philosophic considerations of the nature of person, of individual, and of society. As and when social work education involves itself more formally in values and ethics, it will undoubtedly discover that it has to reach out into the vast range of general philosophy. Schools which already have experience with a values and ethics sequence have learned how difficult and complex their task is with students who have not received a fairly broad philosophy base in the undergraduate years.

In her treatment, Mrs. Pumphrey has gone to pains to present impartially and with understanding variant value bases. She does however seem to construe what she calls the belief "that ultimate values have been ordained by supernatural forces," as something opposed to "the natural." This would be preternaturalism. Catholic supernaturalism holds that values, although ordained by God, are contained within and stem from the nature of things, such as the nature of man, the nature of society. This is the natural law philosophy which obtains a far wider adherence than that of any one religious group, and provides the value basis for most of our positive law. Many who have never heard the term itself give implicit recognition to it, and men of very different beliefs (or unbelief) are able to cooperate in so many areas of social action because they tacitly acknowledge it.

The Pumphrey report is a mine of valuable material, and it might well be required reading for every social worker. No social work educator dare not read, mark, and inwardly digest it. Both volumes of the curriculum study reports here referred to represent a real contribution to the ongoing development of social work education and social work practice. Their value does not necessarily lie in the answers they provide, and many of the answers are very debatable. But they do put the questions, pertinent questions, and the beginning of wisdom is in knowing what the question is.

HEALTH SUPERVISION OF CHILDREN IN FOSTER CARE

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A program for the supervision of the health needs of children in foster care.

CHILD CARE AGENCIES have for many years assumed the responsibility for the medical management of their ill and injured children. But the importance of periodic medical supervision of foster children who are essentially well has been less well recognized.

There are many things which professional workers can do to keep well children well, and to promote the highest possible level of their well-being. Through health supervision, basic health services may be provided for the presumably normal individual, from birth through adolescence.[1]

It should be emphasized that the basic health needs of the child in foster care are no different from those of the child in his own home. The specific content of health supervision required by the child living in a foster home will, of course, depend upon the health conditions of the community. But health supervision should always incorporate four important components:

Periodic appraisal of the child's health status.
Supervision of his nutrition.
Immunization against infectious disease.
Foster parent counseling.

Periodic Appraisal of Child's Health

This is of particular importance in early childhood, because the child is growing, developing and changing so rapidly. Health appraisal should include a thorough medical examination, supplemented where necessary by selective laboratory procedures. Follow-up services should be instituted so that indicated diagnostic and/or remedial measures can be taken. These two steps are interdependent: Periodic health appraisal will be useful only when there are follow-up procedures; conversely, the effectiveness of the follow-up procedures depends greatly upon the adequacy of the health appraisal itself.

The frequency of health appraisal examinations should depend on the child's age and his changing health needs. The following schedule has been found to meet the needs of most children in foster care:

Age of Child	*Frequency of Medical Examination*
Birth to 6 months	monthly examinations
6 months to 1 year	bi-monthly examinations
1 year to 5 years	semi-annual examinations
5 years to 16 years	annual examinations

Whenever possible, appropriate laboratory procedures should also be included in the health appraisal. Routine urinalysis is both simple and inexpensive and should be performed annually. The Mantoux (tuberculin) test, which when positive indicates exposure to active tuberculous infection, can be done in early infancy and repeated when the child reaches school age.

Towards the end of the pre-school period, screening tests for vision and hearing become important and should be performed bi-annually during the school years. The Massachusetts Vision Test is an example of a screening procedure which has been designed

[1] E. Schlesinger, *Health Services for the Child*, McGraw-Hill Book Company, Inc., N.Y., 1953, chapter 15.

for use in childhood.[2] It may be administered either in the physician's office or in the classroom. Children failing to pass this test should be referred to an ophthalmologist for further study. Children with actual or apparent hearing loss may be identified by means of screening tests which utilize the pure-tone audiometer.[3] These tests, which can be carried out in the school, will help to identify children who should be referred to an otologist.

Supervision of Child's Nutrition

The importance of nutritional factors to optimum health is now generally recognized. Foster parents are apt to find themselves subjected, through mass media of communication, not only to much information about the nutritional needs of the child but also to considerable misinformation. High pressure advertising and cultural food folklore both contribute to this state of affairs.

Foster parents need understanding of the authentic nutritional knowledge which is available. This is best provided as part of the general health supervision of the child.

Immunization

Communicable diseases of childhood still constitute important potential causes of both sickness and death. Within the first two months of life, children should be immunized against smallpox, diphtheria, whooping cough, tetanus and poliomyelitis.

A childhood immunization schedule which can be recommended is:

A. *Initial Series*

Age	*Biological Product*
2 months	*D.P.T.—Polio Vaccine
3 months	D.P.T.—Polio Vaccine
4 months	D.P.T.—Polio Vaccine
5 months	Smallpox Vaccination

B. *"Booster" or Reinforcing Doses*

Age	*Biological Product*
1 year	D.P.T.—Polio Vaccine
3 years	D.P.T.—Polio Vaccine
5 years	D.P.T.—Polio Vaccine and Re-Vaccination
10 years	†D.T.—Polio Vaccine and Re-Vaccination
15 years	D.T.—Polio Vaccine and Re-Vaccination

* D.P.T.—Polio Vaccine: Quadruple vaccine containing diphtheria toxoid, pertussis vaccine, tetanus toxoid and poliomyelitis vaccine.

† D.T.—Polio Vaccine: A combined vaccine containing diphtheria toxoid, tetanus toxoid and poliomyelitis vaccine.

Foster Parent Counseling

Foster parents, like natural ones, need help with the many kinds of medical problems which arise in the course of normal child growth and development. Their needs for counseling may be considered under three broad headings:

Requests for advice regarding specific problems of child care—e.g. methods of preparing formulae, feeding problems, recognition and management of the common communicable diseases, sleep disturbances.

"Anticipatory guidance"—This term is used to indicate the help which the professional worker can give the parents by anticipating and interpreting such developmental events as bowel and bladder control, sibling rivalry, aggressive behavior and menstrual difficulties.

Reassurance—As every experienced caseworker knows, foster parents need not only technical guidance but psychological support. They want to be reassured that the foster care which is being provided for the child is not only meeting his needs, but is in accordance with agency policies.

Who does this parent counseling? The physician and the nurse have important responsibilities, but the caseworker, because of his relationship with both the child and the foster family, can complement and reinforce their efforts. It is assumed that the caseworker has (and he should have) a good understanding of the basic health needs of the child and is aware of the normal variability of growth and development. The case-

[2] Marion M. Crane, M.D. *et al*, "Study of Procedures Used for Screening Elementary School Children for Visual Defects," *American Journal of Public Health*, November 1952.

[3] Samuel M. Wishik *et al.*, "Audiometric Testing of School Children," *Public Health Reports*, March 1958.

worker's role begins in his first contacts with the foster family and should continue throughout the time that the child is under care.

In addition to certain special needs related to his disability, the handicapped child has the same basic need for health supervision as the normal child.

Our concept of what constitutes a handicapping condition has changed rather significantly in the past ten years, and we now use this term to apply to a child who has any type of disability which interferes with normal activity. This definition includes both physical and emotional problems as well as long-term illnesses.

The agency serving handicapped children in foster care should be responsible for seeing that the handicapping condition has been accurately identified, treatment has been initiated, a prognosis has been established, and the needs for medical care in the future have been determined. Only then is the caseworker in a position to make permanent plans for the child.

Health of Those Caring for Children

Most states' regulations now require that prospective foster parents, and the other members of the household, undergo a medical examination before approval of their home. As a part of the medical study, the physician should be asked for his opinion about the couple's capacity to provide adequate child care.

Such regulations are meaningful only when the medical study is carried out by a properly qualified physician and repeated annually, and when the medical information gained is made available and adequately interpreted to the agency.

Because contacts between the professional personnel of a child care agency and the children coming under their care are frequent and intimate, a program of health supervision for these staff members may be considered a part of the total child health program.

A minimum personnel health program is one which provides for a complete preemployment medical examination of all new staff members. This may be carried out by a physician or clinic staff designated by the agency (which will pay for the examination) or by the applicant's family physician (in which case, the expense is appropriately incurred by the applicant).

Periodic medical examinations of agency personnel should also be required. The cost should be borne by the agency. For those under forty years of age, a bi-annual examination would be a minimum requirement; staff members forty years of age or over should have an annual examination.

Administration of Health Program

Agency services designed to promote child health and prevent illness are best administered as a part of the total health program. There is no single blueprint for providing child health services which will be suitable for all agencies. The best plan will be one which takes into account the size of the agency and the extent of its responsibilities, and also the size, resources and problems of the community itself.

The success of the child health program will depend upon the simplicity and clarity of agency structure, and on the adequacy of medical resources and the effectiveness with which they are utilized.

Agency structure will vary with the size of the agency, its source of support, and the extent of its responsibilities to the community. The structure must be clearly defined so that the total agency program, of which the health program is but one part, may be administered with efficiency.

Whatever the administrative plan, the medical resources should include the services of a pediatrician, psychiatrist, child psychologist, public health nurse and dentist. These people will provide both direct and consultant services and will act as advisors to the director of casework services; depending upon the size of the agency, they may be engaged

on a full- or part-time basis. Community health resources should be utilized to the fullest possible extent. The community well-baby clinics and the public health nursing services are of particular importance.

It is essential that some member of the agency's staff undertake to coordinate the medical and para-medical resources. In smaller agencies, this responsibility may be assumed by a member of the casework staff. In large ones, it is preferable to assign them to a full-time qualified public health nurse who has had graduate training and experience in both hospital and community nursing.

The objectives of the child health program must be understood and accepted by the entire agency staff, including the part-time consultants. This can be accomplished by a well-planned program of staff orientation and in-service education. While such a program will be of particular importance to newer staff members, it will also be needed by the more experienced members of the staff whose academic backgrounds have lacked sufficient consideration of child health.

Conclusion

The steady development of newer and more effective techniques of health appraisal makes it essential that the agency's child health program be reviewed at regular intervals, preferably by both medical and casework staffs. Each periodic review should involve a re-examination of the program objectives as well as the methods and procedures.

The concept that all children require and profit from regular medical supervision, when they are free from illness as well as when they are sick, is receiving increasing emphasis in current pediatric practice. Child care agencies, which often tend to focus their medical efforts on the sick child only, must recognize also the importance of providing health supervision to all children in foster care.

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CREATIVE RECORDING—SOME FURTHER COMMENTS

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A discussion of questions on form and use of recording that have been troubling the field.

FOLLOWING publication of "Creative Recording,"[1] I attempted to test out the basic thinking implied and openly expressed in that article. Independent of the committee,[2] I conducted discussions on creative recording in workshops, institutes and individual discussions; in addition, a few workers experimented with various forms in an effort to devise a structure suitable for individual cases. As a result, it became clear that many problems still existed and that much more clarification was necessary before any sound, specific guideposts for recording could be developed.

No worker I talked with seemed satisfied either with the task of recording or with its end results. Workers invariably felt that the use to which they put the written material did not warrant continuation of time-consuming traditional methods of recording. At the same time, there was strong resistance to trying to alter the traditional patterns. Far too many workers were content to evade the problem, which they saw as a professional "skeleton in the closet." Denying its existence would cause the problem to fade away.

The conflict and the anger became intensified as workers realized that on the average they were devoting approximately 15 to 20 percent of their time[3] to an activity which seemed to them of "questionable" professional quality, since they were using their own recorded material only about 2 percent of their work time.[4] And few if any workers felt they could stand up and say with pride that their recording, even when they did use it, was of any great help.

Administrative Problems

The problems for administration have been apparent for a long time. Frings[5] speaks of the periodic backlog of undictated cases with its complement of intensive pre-vacation recording, followed by a new accumulation of untranscribed dictation. There is also the great variability in length, detail and quality of case records, not only among workers but even within any one worker's practice. Administration also has to consider the value of maintaining lengthy case records of closed cases in the event that sometime in the future a client may reapply, or a "report on a closed case" need to be written.

By and large administration has been concerned with the necessity of reducing recording time and the length of records. But perhaps such attempts have not been successful because of failure to understand the problem.

The practitioner shares equally with administration in this failure, since before any attempt can be made to shorten records, we all need to decide on their purpose. Then we may be able to say what must be in the record and what may or should be discarded, and why. Only answers to these questions will enable us to know how best to organize the material. We cannot afford to look for short-cuts alone.

The Purpose of the Record

The earlier article on creative recording noted that the record "is a tool to further the

[1] Sarah Stone and Edith N. Kerschner, "Creative Recording," CHILD WELFARE, January 1959.

[2] Region VIII, Case Record Exhibit Committee, Child Welfare League of America.

[3] John Frings, "Experimental Systems of Recording," *Social Casework*, February 1957.

[4] *Ibid.*

[5] John Frings, *An Assessment of Social Case Recording*, Family Service Association of America, New York, N. Y., 1958.

service provided to the client."[6] At the time this was written, the statement seemed clear enough, and neither in the literature on recording nor in any of the formal discussions I conducted has it ever been challenged. However, as we attempted to understand our current records and our problems in recording in the light of this purpose, we discovered it to be of little immediate help in trying to solve the problems of recording.

There is a tacit acceptance of the idea that records serve many purposes. For example, Gordon Hamilton writes:

"The dominant consideration of keeping records is that of service to the client—records are for professional use—they are designed to help the worker in a realistic, practical way to serve the client's interest and to further social work knowledge in the interest of the client."[7]

In his recent publication Frings states:

"It appeared that substantial information was needed on the essential requirements of a case record, the uses to which it is put. . . ."[8]

Hamilton says that the record has many purposes; Frings says that a record should contain certain basic information and raises the question of the purposes of this information. The literature in general encompasses a broad meaning: It speaks of direct service to the client—i.e., something to be used in daily practice—and it speaks of administrative uses, of records for teaching purposes, of records for research.

Recording as Accumulation

Out of the expectation that records would contain what everyone—practitioner, administrator, teacher and researcher—would need at some time, our records inevitably became a massive accumulation of every conceivable kind of information. The worker was driven by the feeling that to lose a word was somehow to fail someone. Also, social work records developed no really identifying characteristics, unlike the records on individual cases of other professionals. For example, a medical record is recognizable by all members of that profession. And a legal record has its own identifying characteristics.

It would be difficult to justify the position that social work records have identifying characteristics of their own. Most of us would agree that they are marked by verbosity, irrelevance, disorganization, and lack of selectivity, clarity and balance. They really have no professional stamp. Moreover, it is coming to be recognized that our records do not serve well at least a couple of the purposes we traditionally have assigned to them: formal teaching and research. Frings is very specific in regard to this matter.[9] He writes:

"Two uses of case records were immediately excluded from the study: (1) use in future research programs in the agencies and (2) use as group-teaching in seminars, institutes, or classes. It was agreed that the usual case record was not a valuable or reliable source of material for research programs; that, in general, data were more useable when collected specifically for the purposes of a particular research undertaking, and that possible future research was not in itself a reason for record keeping. In the same sense, although it was agreed that while agencies have a responsibility to supply teaching material as needed, records were not kept in the agencies for this purpose. . . ."

If we recognize that records maintained in the usual fashion, in the usual agency, are not suitable for teaching or research or community planning, then we need to ask ourselves whether they are most suitable—whether they are best constructed and most clearly fashioned—to offer direct service to the client.

It would be well to review the 1958 definition of dynamic recording as developed by the Case Record Committee:[10]

"Dynamic recording is a highly organized form of written communication of primary facts and

[6] Sarah Stone and Edith N. Kerschner, *op. cit.*

[7] Gordon Hamilton, *Principles in Social Case Recording*, Columbia University Press, New York, N. Y., 1946.

[8] John Frings, *An Assessment of Social Case Recording.*

[9] *Ibid.*

[10] The term "dynamic" was later changed to "creative."

feeling tones, sharply yielding the presenting problem(s), diagnosis, treatment, treatment planning, movement and conclusions with accuracy, clarity, balance, unity and selectivity."

This definition speaks of something which is not merely in the interest of the client but is specifically *about* the client. Earlier, we not only did not have an answer to the question, "Whom is the record about?" but even more serious we did not realize that this question needed to be asked. We have therefore persisted in developing large masses of undigested material bearing no professional stamp.

The Record Used as Teaching Tool

The responsibilities for teaching and learning, through agency supervisors and through classroom teachers, probably have created much of the confusion about what the record should contain. Since schools for social work training were first developed some fifty years ago, no school, to my knowledge, has taught separately and specifically a course in interviewing. There is relatively little literature on interviewing as such, even though it is the major tool used in providing service to the client. Almost by default, learners developed interviewing skills as they sought to understand the client and his reactions and what kind of help he could use to improve his situation.

Because we wanted and needed to help the learner interview more skillfully, we began to expect the record to reflect the interview to some degree. Thus the record soon reflected material about the client *and* the worker's struggles to understand and to deal with this material. In the reality of the interview, and in the supervisory conference, these two threads are intermingled. But in the record they probably should not have the same intensities.

It is true that the teacher (supervisor) has not only the right but the obligation to challenge a worker to "account" for everything he does within the interview; that is, to challenge him to demonstrate the professional knowledge and skills he called forth when face to face with the client. But if the record is about the client, then the knowledge and the skill which the worker brings to bear within and without the interview will be implicit in the record, rather than a primary and direct aspect of it. The record will be about the client as the worker sees him, and it will bear a professional stamp insofar as the worker himself is able to place such a stamp upon it. We would avoid saying to the beginner, as this writer herself did in her early years of supervising, "Don't show me the picture you drew, rather show me how you drew it." This is a perfectly legitimate request to make of a beginner in the supervisory conference, but this should not mean license to write the "how" into the client's record.

Because this approach to teaching not only was permitted but actually encouraged, we now find that even the long-experienced, skilled worker often is recording in a way not too different basically from when he first became a social worker. His pattern has become so deeply entrenched that he finds it almost impossible to change his methods of work.

Teaching New Kind of Recording

If emphasis is placed on transferring material related to the learning struggle away from the case record, we must determine at what point in the worker's career it is appropriate to expect that he begin to learn to do this new kind of recording. From experience, I believe that this should be expected from the very beginning, as the learner takes hold of his first field work experience. In supervising students, it has been possible, with varying degrees of success, to help the young worker involve himself creatively. Rather than fragmenting the material within and between interviews as he writes, it has been possible for the most inexperienced to create some kind of meaningful whole. This does not mean that the written picture needs to be a static one. Moreover, it can bear the stamp of the knowledge and skill of the worker. But it would be a picture of the client. This means the beginner would start with a pattern of writing different from the

traditional form; the experienced worker would have to refashion his writing techniques.

Resistance to such a way of developing and maintaining records has come from two widely different sources: First, it has come from those who are involved in classroom teaching of casework. It is understandable that if agency records were to reveal the worker's role only by implication, classroom teaching of casework would need to undergo some important changes. Probably much more overt attention will need to be given to the problem of *how to interview* within the context of certain specific types of situations. For example, how would the worker handle himself with an acting-out, impulse-ridden child? How would the worker handle himself with a paranoid schizophrenic? We will need to be much clearer than we have been when we talk to the beginner about "supportive therapy."

The second source of resistance has been those who have recognized the great importance of the worker's reactions, feelings and personal problems, which enter into and sometimes interfere with the quality of service rendered the client. There has developed over the past thirty years the tacit assumption that if facts about the worker's personality and his problems could be brought into the record, they somehow would be dealt with more effectively by supervisor and administration than if the only place for detection were the supervisory conference. It is this development, perhaps as much as the need to teach interviewing skills, which accounts for the confused, disorganized and unbalanced records which exist today.

Content of the Record

If we agree that the record is about the client, then it should not be too difficult to determine with clarity what it should contain. All records should have in common not specific content, but rather that which identifies the content as social casework—that is, the quality which marks the material professionally. In this connection it hardly seems necessary to become involved in the long-standing dispute about whether or not workers should use technical language. It is possible to use such language if this is the way a particular agency functions. Thus one worker may speak of concepts relating to *diagnosis*, *treatment*, *responses to treatment*, *prognosis*. But for another worker, in a different agency, it is possible—and incidentally sharpens the quality of thinking about a case—to ask:

> "Why does the client come to this agency?" "What does he think he wants?" "What does the worker think he wants?" "What kind of person is the client?" "What can this agency offer him?" "What does the worker think will happen to the client in the near—or far—future?"

These are basic casework considerations, and the manner in which they are placed in the record obviously will depend upon the kind of training and the degree of skill which the worker possesses as well as upon the agency's requirements. Similarly, supportive evidence will depend upon the kind of situation and the reliability of the worker's skill as well as upon the particular kind of treatment program the client requires. For example, the record of an adult male, receiving treatment for personality problems, may require no more than such a simple statement as, "In the past ten years Mr. Boyer has had eight different jobs, none of them in the field of work for which he was trained." On the other hand, the beginning record of a child client receiving treatment for personality problems may well require considerable detail about early developmental history, as well as parental management of behavior during early history. Volume, in itself, does not insure reliability in evaluating case material.[11] It is sometimes used, perhaps unconsciously, as an escape from the responsibility to think creatively about the material one is setting forth, to apply the intellect so as to produce a new construction out of existing materials. The new construction will be fashioned from professional requirements. It will be grounded in self-questioning, self-

[11] Martin Wolins, "The Problem of Choice in Foster Home Finding," *Social Casework*, October 1959.

challenging, balancing, making and re-making if necessary. At the same time it will be rewarding, as no mere setting down of memorized facts and observations ever can be.

As I presented these ideas to institute members, requests for an outline, "so that we can know what to put into the record," frequently were made. There is a great temptation to accede to such a request, especially as some of my colleagues and I were experimenting with outline forms of one sort or another. The danger in an immediate response to this request is that such outline forms inevitably would lack basic essentials.

Our Case Record Committee devoted three years to developing some kind of operational definition of creative recording. Although some attempts were made during those years to apply the evolving definition to actual case recording, none of the members were, nor are they yet, satisfied that the *how* has been achieved. Moreover, it was recognized that thinking and ability to abstract and conceptualize are essential processes if we are to achieve any kind of success in dealing with the problem of recording. This will be difficult for many, for a number of reasons: First, we are unaccustomed culturally to thinking abstractly, to conceptualizing; secondly, we are so entrenched in the traditional habit of doing that change is exceedingly difficult; thirdly, many, out of sheer laziness and lack of pride in their professional life, have insufficient interest in trying to do something better.

Developing a Professional Style

To compose an acceptable "outline," we will have to develop some sense for professional style. Whitehead[12] describes this as "the most austere of all mental qualities." It is based on "the direct attainment of the foreseen end, simply and without waste." It has the aesthetic qualities of both "attainment and restraint." In its finest sense, it "is the last acquirement of the educated mind; it is also the most useful. It pervades the whole being. The administrator with a sense for style hates waste; the engineer with a sense for style economizes his material; the artisan with a sense for style prefers good work. Style is the ultimate morality of the mind."

With the development of a proper mode for expressing ourselves—a professional style—we would be better able to attain our end, which is better service to the client. A proper professional style would be purposely calculated to demonstrate the effect of the worker's activities, thus demanding of him a conscious professional interpretation and evaluation of what has occurred, of what bearing one aspect of the client's situation or the worker's activities has upon another aspect. The worker would need to be "trained in the comprehension of abstract thought and in the analysis of facts."[13]

Experiment with Organizing Records

Knowing our goals, we would be in a position to consider "outline." For example, we know many important aspects in which an outline for a foster home study should differ from that of an adoptive study. We know that an outline for the study process of a child being considered for treatment of personality problems would be different from an outline for on-going work with a client. We know that although we deal with individual situations and with individual kinds of agency services, there are some common factors in all cases. It is this which makes learning possible.

Space does not permit the inclusion here of actual case recording, but during the past year the writer and a few colleagues did attempt to dictate at least parts of records in accordance with the thinking expressed in this paper. We found that an "outline" seemed to serve only as a very general guide at best. Each case seemed to demand its own guide, with some common features and some unique ones. The latter were related to the nature of the service offered by the agency as well as to

[12] Alfred North Whitehead, *The Aims of Education and Other Essays*, The MacMillan Company, New York, N. Y., 1929.

[13] *Ibid.*

individual factors even within such a service. It seemed that more important than developing an "outline" as such was the need to bring together into some conceptual framework material which belonged together, even though it may have been elicited over a period of several interviews, and to separate material which was disparate.

Many of the cases dictated in this experimental way began with a paragraph or two entitled *Situation*. Here were found facts, events and other concrete specific occurrences in the life of the client since the previous recording period. This grouping of information usually was followed by *Treatment*, encompassing a very broad area of activity. Here were such items as:

"The child was placed from his own home to that of Mr. & Mrs. Arnold on May 12," and "Because of the nature of this child's personality, as determined in previous diagnostic evaluation, worker related himself to the acting-out presented by the child during the office interviews" in such-and-such a way.

Obviously, in the actual recording this material was presented in more detail and with greater fluidity than can be summarized here. *Responses to Treatment* was another grouping. In some of the illustrative material, workers apparently felt that *Treatment* and *Responses to Treatment* could not be separated, and thus combined the two.

Almost all the records contained some special categories which had significance either for the specific case or for the specific period of time involved. For example, one case included a category entitled *The Illness*, which related to significant background information involving the child's eighteen months of hospitalization when he was still a toddler—medical information, the way in which the separation from home to hospital was effected, the nature of the parents' involvement both during the separation and during the hospitalization, the child's reactions to various adults in the hospital, his reactions to traction, etc. In another case, a special category concerned the child's airing of feelings regarding previous treatment in another agency and the worker's help with this. All records contained a category entitled either *Evaluation* or *Diagnostic Thinking* and all contained *Future Planning* or *Next Steps*.

The use of some such categorization of material would have a style related to the profession of social casework. It would put demands upon the worker to make a conscious professional interpretation and evaluation of what has taken place in totality for a given period of time. The worker would need to analyze the facts and he would be compelled to train himself to combine the elements of a situation into some kind of professionally meaningful whole.

In Summary

I believe that the record needs to be *about* the client. This does not mean that the therapeutic agent may not, does not, or should not appear in the record. But it does mean that the methods for helping the client achieve change would appear in the record only in a kind of tangential fashion, and the worker's learning struggles to refine methods of applying treatment would be a primary concern in an area outside the client's records. Above all, it *does* mean that the client's responses to treatment are primary and predominant.

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PSYCHIATRIC CONSULTATION WITH STAFF OF A MATERNITY HOME*

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A discussion of changes that may occur in a staff as a result of psychiatric consultation, viewed not only as dissemination of knowledge but as help with individual differences in applying knowledge.

THE PURPOSE of consultation has been described as staff development. In great measure this means actual change in the personality of the participant, rather than education in the usual sense.

In a social agency, such as a home for unwed mothers, there has been opportunity for an exchange of ideas and feelings among the staff members and others before a consultant comes on the scene. Those who have been able to make use of such a situation have gained increasing insight into others and themselves—with resulting changes in their personalities. However, such a situation may become static and "growth" stop. The personalities of the staff members interlock and various needs become satisfied by patients and other staff members. When this occurs there is neurotic investment in maintaining the status quo. The problems of the patients come to be seen in a limited perspective.

This kind of "stalled" situation interferes with adequate handling of the patients, as needs are being acted out rather than understood. A consultant who deals with the entire group may function as a catalyst to keep this process of change going.

In the situation which I have described, the consultant would be involved in what may be thought of as a particular kind of group therapeutic process. It is a process structured in a special way around a core of technical information, but it is therapeutic because it depends for its effectiveness upon alterations within the personality of the consultee.

There are limitations to the creation of such an atmosphere in any kind of consultation. The limitations in group consultation are created by the lack of intimacy between the consultant and consultee. The particular advantages lie in the opportunity for both the consultant and the consultee to see, in broader perspective, the emotional reactions of the participants within the group toward other members of the group and themselves.

The consultant is limited in his work with an individual consultee by the awareness that actual interpretation is usually not his function. Also, he knows that he is not, as a rule, in a position to follow through with the therapeutic implications of interpretive work. In group consultation this is certainly the case, and there is the further problem of having to expose the consultee to others as well as to himself. However, the consultant may help people to become aware of their defenses, identifications, transferences and counter-transferences by other means than direct interpretation.

Worker-Patient Interaction

Anyone working with another person's emotional problems, whether directly in psychotherapy or not, needs to be able to perform certain psychological actions which require for their greatest effectiveness a mature, flexible and introspective person. The worker must be able to identify himself with

* Given under the auspices of the National Association on Service to Unmarried Parents at the National Conference on Social Welfare, San Francisco, California, May 28, 1959.

the patient in order to experience the patient's problems. At the same time he must be capable of maintaining an objective, observing part of himself so that he may see what his feelings would be were he the patient. This gives him insight into the nature of the patient's feelings and behavior. He must then be able to divest himself of this identification so that he does not become so absorbed in it that he can no longer be objective.

In addition, the worker must be able to react emotionally to the patient as a separate person and then observe these reactions. This gives him insight into the effect the patient has on others, diagnostic clues, and also valuable information about the forces motivating the patient's behavior. The worker must remain objective enough to observe these reactions and restrain himself from behaving on the basis of his feelings alone. For example, being aware that one is reacting with irritation to a patient's behavior may be evidence of the aggressive, provocative nature of such behavior. Awareness of sexual feelings may give evidence of a patient's seductiveness. But the worker must check these reactions against other knowledge of the patient and knowledge of himself before he can know with any certainty whether his response has meaning in terms of the patient or in terms of himself.

The personality and emotional problems of the worker are deeply involved in these processes. The worker must be aware enough of his own problems so that they do not become confused with the problems of the patient. The worker must also be able to develop enough of an observant ego so that self-observation and observation of the patient occur at the same time that he is identifying himself with the patient and reacting to him. The worker must be able to tolerate fairly intense degrees of feelings toward the other person involved without precipitously acting on them.

Whenever one person has a relationship with another, his ability to see the other person objectively is clouded to some extent by his own emotional problems and needs. When objectivity toward a particular person is considerably disturbed by emotional problems, one is unable to assess adequately the problems of that person. The individual is generally not able to be fully aware of the kinds of problems that are clouding his objectivity. This confusion may exist in any relationship, whether with patients or other staff members.

Emotional Problems of Staff

The close proximity of staff and patients in a maternity home provides a rare opportunity for observation of behavior. But it is the kind of situation in which strong emotions are aroused and acting out may easily occur. The patients have a relationship not only with each other but with the staff as a whole, and in a varying degree with the individual members of the staff, persons from an adoption agency, family, friends, board members, doctors, the unborn child, etc. Handling of the patient within the maternity home setting or any other social agency may become confused not only by the clouded reactions of employees to patients but also by the reactions of members of the group to each other, their supervisors and the consultant. "Acting out" between members of a staff is reflected immediately in the feelings and behavior of the patients. The group consultation represents the total situation in miniature and becomes a part of the relationships within the group.

While the emotional problems which can cloud the situation may be broken down under certain headings for discussion, it must be remembered that the disturbance is rarely the result of a single factor. The kinds of difficulties that a given individual has tend to show up not only in his relationship with the patient but also with others. These difficulties may be seen in the process of the consultation, in his relationship to other members of the group or to the consultant. One cannot always know with certainty the origin of the disturbances that are involved—that is, whether they are due to the defense

mechanisms of the individual, over-identification or transference problems. Often there is a combination.

One rather commonly observed difficulty is that produced by defense mechanisms. Feelings of anxiety, guilt and shame may force defensive maneuvers by the worker in response to the patient or others. He may need either to avoid seeing problems which arouse such feelings or else to deal with them in a distorted way. One employee was rarely able to tolerate in herself any feelings of hostility. They were rigidly repressed and the surface attitude was one of an inflexible sweetness, sympathy and kindness. Such inability to recognize one's reactions interferes with understanding of the patient's behavior. Repressed hostility may become unconsciously associated with firmness. It then becomes very difficult for the worker to deal firmly with a patient, even when this is clearly indicated therapeutically. The same attitude can exist about many feelings present in patients which may arouse guilt or fear. Dependent needs, for example, may have to be defended against and therefore their importance may not be seen in the patient. Sexual feelings may arouse anxiety, guilt or shame, which also may be handled by various mechanisms of defense.

In the necessary process of identification with the patient, one may become involved in what is known as an over-identification. This is most apt to happen when the employee shares unconscious impulses or character traits with the patient. If he identifies himself with the patient so thoroughly that he tends to lose sight of the patient for himself, he may deal with the patient as he wishes someone would deal with him and may see the patient's problems as he sees his own. The employee may then be so "sympathetic" that he cries with a patient over his problems and can see him only as the unfortunate victim of fate. Over-identification helps to fortify the forces within the patient resisting the recognition of his emotional problems. Whether these are eventually to be explored with the patient or not, it is harmful when, for personal reasons, the social worker must not see them.

One must be able to identify in order to understand. But it sometimes becomes extremely difficult to identify with the other person either because his problems are too remote from the worker's experiences or too close and disturbing to allow identification.

Transference and Counter-Transference

Transference may also become a major problem. Not only may an individual have feelings toward a person which he once had toward an earlier, more important person, but he may perceive the later person in the image of the other—without conscious realization that he is doing so. Thus he also feels the other person is reacting toward him as he once felt the earlier person did. This reaction is modified somewhat by the conscious awareness of the real person, so that a kind of distorted image is produced—like a double exposure. The more similar the two persons are—in physical appearance, personality or position—the easier transference becomes and the more difficult it is to separate the reactions. A director may easily be regarded as being in a maternal or paternal position; a fellow employee or patient may be seen as a sibling.

The emotional response to this transference is *counter-transference*, in a general sense any emotional reaction by one person to the transference feelings of the other. An individual may respond with affectionate feelings to a person who, in transference, obviously regards him with admiration. This may be simply the response of the individual to having an emotional need gratified. On the other hand, one person may respond to the transference of another with a feeling that is of a transference nature itself and this, too, would be a "counter-transference." For example: One of the staff members may have had an older sister who played an important role in the family. If the director has been an older sister, it is quite conceivable that these two persons may repeat the old relationship, each transferring to the other the image of the person important from the past.

These reactions need not interfere with the functioning of the staff. Indeed, awareness of them may throw valuable light on one's own behavior, the staff and the patients. However, when they remain unconscious, such reactions lead to inappropriate feelings and behavior. The whole working structure of a staff may revolve around transference and counter-transference relationships and become set in a complicated acting-out, gratifying various needs of the staff and patients with little conscious awareness of the bizarre and untherapeutic atmosphere.

In addition to the roles played by the defenses, the transference and over-identification, there is the somewhat different role that the unconscious or only dimly conscious characterologically fixed needs play. By this I mean those needs that are so much a part of the character structure of the individual that, while they may vary in their intensity with the particular transference relationship involved, they are nevertheless present in all situations, and demands to have them gratified are diffuse. For example, an all-pervasive need for approval will manifest itself not only in relationship to the patient but to other members of the staff, the director and the consultant. It becomes very difficult for a person with a deep-seated, characterologically rooted need for approval to behave in a way that he knows will meet with disapproval, whether from patient, friend, colleague, consultant or director.

Structure of Group in Consultation

With this background, let us return to the structure of a group in consultation. In this maternity home, the staff members were all women. There were secretarial and office staffs, the kitchen department, nurses, and the administrative personnel. This group had already been established before I came, and there was a rather wide range of relationships. The sibling rivalries among the staff members, the struggles involving latent sexual problems, identifications with the patients, set attitudes of being "kind" with an incapacity for firmness, and attitudes built around the concept of sinfulness all played their part. There were individual needs being acted out within this group, and almost everyone had a particular ax to grind. However, there were also eager, flexible and insightful persons within this staff.

I felt that the entire group having contact with the patients should be oriented to deal as effectively as possible with them, so that there would be a minimum of acting-out to interfere with the general plan of treatment for a given patient. I had no direct contact with the patients because I felt that my limited time could best be spent with the staff, and consultation for the individual patients could be achieved with other psychiatrists. Reactions to the idea of consultation ranged from interest to downright hostility. There was also fear of what this consultation might mean—such as exposing deficiencies and interfering with established practices. While appearance at the consultation group session was not mandatory, it was clear to the staff that the director was interested in their participation and the staff members by and large attended, some out of personal interest in consultation, some because of other needs.

Ordinarily we think of consultation as a relatively uncomplicated situation. However, the needs of the consultant and consultee in the relationship influence the process. These needs vary from time to time, as a result of other relationships outside the consultation session. The needs of the consultee for approval, his fear of the consultant, or whatever his transference feelings may be, are involved. The needs of the consultant also play their role: The weather at the moment, the consultant's digestion, his needs for omniscience, his fatigue, all play their part. One is inclined to forget that the patient is also a member, although in absentia, of this group—and not only the patients but also the babies, the unwed fathers, the families, the board members, the adoption agencies and so on and on involving a wide community.

Techniques of Consultation

I began my maternity home consultation with the assumption that the staff members

were desirous of learning, that technical information was of prime importance, and that they were working in a maternity home because they were interested in emotional problems. I was surprisingly slow in learning that this was not always the case, until finally I realized that I could not expect to "teach" in the ordinary sense. My relationship with the group changed to involve a greater awareness of the people who made up this group, my relationship to them and theirs to me. I came to feel that while we would be discussing patients and patient problems, my function would mainly be to see if these discussions could increase the ability of the staff to use this material.

For some time I was regarded mainly as a source of irritation. The ability of members of the group to express openly their disbelief or anger varied. The sessions seemed to stimulate discussion outside the group consultation. My efforts were largely aimed at asking questions, which sometimes penetrated defenses or exposed problems in thoughts and feelings. The absence of final answers was of course frustrating, but appropriate questioning almost always led one or more of the staff members to provide the reasons for a certain kind of handling of a problem.

An employee may sometimes be unaware that she is not behaving with the patient as she had consciously intended. I have seen efforts to clarify such a distorted relationship result in anxiety, confusion and withdrawal. When the consultant pursues the discrepancies, exposing distorted relationships, other members of the group may respond with hostility because of their own fears or protective feelings toward the employee involved. Whatever their basis, open expression of these reactions should be encouraged, for they are part of the matrix from which the individuals involved can build a greater understanding of themselves and increased flexibility in their work.

The Personality of the Consultant

In discussing group consultation from the standpoint of the consultant's techniques, one factor is clearly dominant: the personality of the consultant. (Here I use "personality" as a broadly inclusive term.) The way in which the sessions are conducted will depend in great measure on this factor. There is no universally ideal consultant personality, since this must necessarily vary with the character of the group. But the consultant must be able to work with the group and within the group. He must gain some measure of acceptance and be able to find a common ground for communication.

This does not mean, however, that you seek a consultant who is unthreatening to the group. If the consultant disrupts the acting-out within the group he is bound to be the recipient of some hostility. One who would himself become enmeshed in the acting-out already present is useless. If the consultant does not disturb the fixed structure of the group, he serves little purpose other than to allow the agency to become more fixed in its status quo, to feel justified in this, and to be able to say they have "consultation."

The consultant who seeks changes within the staff must himself be prepared to change and not simply impose his ideas on the group; yet he must also be able to influence the group to avoid harmful decisions. The techniques used resemble those of the group discussion leader who seeks to set a process in motion, to keep it moving, but not to dominate it. Effort is aimed at drawing everyone into the discussion. This may sometimes be done by direct questioning, but in other instances nothing but waiting will turn the trick. You must also deal with the worker who tends to dominate the discussion, making it difficult for others to speak freely.

While direct interpretation is almost never useful, there is a kind of indirect interpretation that the consultant may use. In the patient material there is often opportunity to focus on problems relevant to something present in one of the workers. This kind of analogical discussion reaches some people surprisingly well. Others will not be budged by any measures known to me.

Still another device is for the consultant to express some of his own feelings about a given patient. The workers may then realize that they can be more free in expressing their reactions. The consultant should also recognize when his initial comments regarding the handling of a problem may not be as pertinent as those of others in the group. Saying so, or admitting fallibility, may allow others to feel they can express their own ideas even if they are not correct. The sooner the group knows that the consultant does not regard himself as omniscient and omnipotent, the sooner they can stop behaving as if they regard him as such. However, the consultant, in one way or another, should insist that the workers think clearly and examine their own feelings and behavior ruthlessly. This is often a great deal to ask. The consultant at times may choose to present arguments opposed to what he believes, in order to stimulate a worker to muster her forces and clarify her thinking. This generally is more appropriate for the mature worker. Many people can think much more clearly and effectively than they realize if somehow brought to it.

In various ways the members of the group revealed the areas of difficulty peculiar to them, and it became apparent that some members of the staff were going to react in typical ways to certain kinds of problems.

A nurse who seemed understanding enough of the younger patients pregnant out of wedlock was rigidly hostile toward women somewhat older, who should "know better."

Then there was the employee who was so eager to see signs of conversion among the patients that those who were oriented to behave as the environment demanded could behave like converts and gain approval without basic character change.

On the other hand one will also see the worker who is comfortable with herself and able to express her feelings in the group; who, when asked, can really say how she feels toward a particular patient, throwing light on the meaning of the patient's behavior. This sometimes loosens the defensiveness of others of the group. There is the worker who can be obviously irritated with the consultant, who will stand in disagreement and thereby allow others in the group to be a little bolder. One is also rewarded by the staff member who begins to see the questions to ask—for I believe that, given a reasonably flexible personality structure, one needs relatively little technical knowledge beyond the appropriate questions and an insistence on pursuing the answers whatever they may expose.

In Conclusion

I do not mean to imply that even an individual relatively free of emotional problems can work effectively without necessary technical information. I do mean, however, that no amount of technical information alone can resolve the problems involved in absorbing this information and using it in relationship with another person.

I suggest that the consultant regard the technical information as of secondary importance. He should be concerned more with an effort to provide an atmosphere in which the staff may have an opportunity to observe themselves and to be stimulated to indicated change.

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CONFERENCE CALENDAR

Central Regional Conference
March 10, 11, 12
Dayton-Biltmore Hotel, Dayton, Ohio
Chairman: Miss Katharine J. Dunn, Case Consultant
Catholic Charities of the Archiocese of Cincinnati
217 North Ludlow Street
Dayton 2, Ohio

Midwest Regional Conference
March 21, 22, 23
Leamington Hotel, Minneapolis, Minnesota
Chairman: Callman Rawley, Executive Director
Jewish Family & Children's Service
404 South Eighth Street
Minneapolis 4, Minnesota

South Pacific Regional Conference
April 7, 8, 9
Statler Hotel, Los Angeles, California
Chairman: Mrs. Barbara Costigan
Supervisor, Day Care Department
Children's Bureau of Los Angeles
2824 Hyans Street
Los Angeles 26, California

CONSULTATION IN A MATERNITY HOME

THE ADMINISTRATION'S POINT OF VIEW*

Sr/Captain Vivian K. Johnson
Administrator
The Salvation Army
Booth Memorial Hospital
Los Angeles, California

BEFORE undertaking a consultation program the director will need to do some real soul-searching. To recognize the need for consultation as a process of staff development is the simplest part of the undertaking, since we all wish to improve our skills and techniques as well as our interpersonal relationships with those whom we serve and work with.

If the director is a sympathetic and understanding person, he is aware of many of the family problems of his personnel and the subsequent pressure this brings to bear on the work-a-day activities. If he is alert he also knows the various rivalries and claims for recognition that are imposed by staff. In his recognition of this he must decide if he can accept some of the hostilities that will result from the interplay of personalities in the consultation room. The director will need to be aware that he will become a central figure in much of this, since any consultation program can only be implemented by him.

Consultant-Director Relationship

It is important, then, that the consultant and the director clarify their relationships to each other. We certainly agree with Dr. Thickstun that the personality of the consultant has great bearing on the success or failure of the program, and we add to this the personality of the director. Each must be equally sure of the position of the other. There must be complete rapport and honesty. The director cannot be protective of staff or of some of the treasured practices of the agency.

The director needs the security of this rapport, for he cannot afford to be threatened by staff behavior problems, or by the presence of the psychiatrist. To receive the greatest benefit from the consultation hour all of this must be properly cleared before the program begins.

The productive aspects are heightened when the director and the psychiatrist discuss between consultation periods the attitudes of staff in respect to the consultation hour and some of their resultant behavior toward the clients, toward each other, and toward the director and the psychiatrist.

The director will of necessity take on responsibility for staff behavior following certain decisions that are arrived at in the consultation period. The staff will have great need to do the direct opposite of many things they have learned. Needing to transfer their guilt to some other person they will frequently say, "But the director says we can do so-and-so."

The director will also need to be able to change as a result of the consultation period. He may see many cherished ideas fall by the wayside. He may see a need to alter some policies and certainly practices will change as a result of the change in the attitudes of staff.

Attendance may not be mandatory, but the director expects them to be there; hence they will go, with all of their feelings of hostility for having to attend. He will need to be sensitive to the many aspects of the personal lives of the staff, but must be able to divest himself of too close identification with them.

The staff will not wish the director to know that they really do not want to attend. They will appear to be eager and anxious and say that they love it, but the discussion between themselves after the consultation will reveal their true feelings. The fact that they can discuss this more freely between themselves than with the director must have meaning to

* Given under the auspices of the National Association on Service to Unmarried Parents at the National Conference on Social Welfare, San Francisco, California, May 28, 1959.

the director as well as to the consultant. The director could well be so anxious for the success of the program as to be hesitant to deal with any controversy in relationship to it. This hesitancy is increased in direct relation to the hostility from staff that may be apparent in the consultation room. Regardless of all of the foregoing, it is most important for the consultant to know where the director stands.

The Staff in Consultation

Our staff had various degrees of training as well as varied interests. It had been the policy of the maternity home to hold regular staff meetings with the entire staff, so that the idea of total staff discussing ways and means of development was not new. It was during the course of these meetings that the need for psychiatric consultation had been considered.

The consultant felt that all members of the staff should participate. There actually seemed to be a certain amount of eagerness on the part of all to get the program under way. Some of this was undoubtedly related to the eagerness of the administration to develop staff.

Perhaps having all the staff added not only interest but conflict to the entire consultation program. The non-professional group was not even familiar with much of the terminology used, and they thus hesitated to participate. It took considerable time for many of them to begin to understand the dynamics of human behavior. It also required patience by the professional people to carry the non-professionals along with them. Fortunately, during this period staff turnover was very low; this aided the entire project.

The interplay of personalities in the group was most interesting. Also of interest were the dynamics of the individuals which led them to confuse their own personal problems with those of the clients. One member of the clerical staff was a married woman, with teen-age children, who was having marital problems. The areas of greatest weakness in her own family frequently caused her to be intensely hostile toward the psychiatrist and to reject completely everything that went on in the consultation room.

There were many dramatic happenings from week to week, but our knowledge of human behavior helped us to know that change in the behavioral pattern is not dramatic, but rather a slow process of give and take. Personal problems may quicken the growth of some people as a result of the consultation. There may be an unconscious eagerness on their part to learn how to handle their personal problems as well as their job-related ones. On the other hand, the personal problems of some staff members will slow them up, and their personality change may be retarded by their very conflicts as they think of their personal problems in relationship to the ones on the job.

Changes in Behavior Patterns

However, we were able to observe staff begin to feel more comfortable about many of their own personal situations. For example, some no longer felt so guilty about the management of their own teen-age children. As their guilt lessened we noticed a perceptible change in their attitude toward the patients. More secure in their own personal feelings, they were able to say how they felt about many parts of the program that heretofore they had been unable to discuss. There was a lessening of staff rivalries. They could question each other on certain cases with much less hostility as cases were presented in the consultation room.

Staff became more secure in relationship to the director as they all participated in the exchange of feelings and ideas. They were able to say how they felt about management without fear of retribution. We observed staff time and time again work out their own feelings about agency policy with which they had not been in harmony, but had scarcely known why they could not agree.

Dr. Thickstun makes very clear the transference and counter-transference that takes place in a group-within-a-group. At least two of the staff members had the acute kind of family problems that produced such guilt in them as they sat through the consultation hour that we could easily have lost them. We watched them move to the place where their own guilt was lessened, and in their resultant security they were able to relate much more readily to the problems peculiar to the un-

married mother. We observed certain other staff members come to find sufficient answers within themselves to maintain their own role in relationship to the patient. For instance, the young girl patient who saw one of the staff as a mother figure would reflect her hostility toward her own mother in her attitude toward this person. We saw this staff member become able to hold her role as a staff member rather than becoming a hostile mother, a direct change from the way she would have reacted before consultation.

In Conclusion

Perhaps the most dramatic result of the entire program was the development of the team approach to all problems, with increasing insight into the patients' needs. We observed that staff no longer wanted to get rid of the unruly, hard-to-handle, psychotic or acting-out unmarried mother. They were able to discuss her during the consultation period, then work together with some very severe problems. They began to see the need for certain limits, and to abide by the limits themselves. There was scarcely any aspect of the personal lives of the staff that was not explored one way or another in the consultation room through case discussions of the unmarried mother. It was most gratifying to watch staff, professional, non-professional and religious, mould their thinking and ideas together in the kind of pattern meaningful to the program. Motivating factors were aired until staff began to see why they felt and acted as they did and were able to bring themselves forward through the medium of the consultation hour.

The consultation hour can be meaningful only when the consultant is in accord with the principles and philosophy of the agency. Administration must be willing to free the psychiatrist within limits of agency policy so he can develop new practices with staff if needed. This calls for flexibility on the part of administration and a willingness to change on the part of staff. The role of consultant, then, is to help create the climate where such activities can take place. This was accomplished by Dr. Thickstun, and all concerned gave evidence of their ability to grow and develop under the impact of the program.

LIVING IN A GROUP: FROM "THE PROFESSIONAL HOUSEPARENT"

Eva Burmeister
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New York City

We appreciate the permission granted by the Columbia University Press to reprint selected sections from chapter 2 of Miss Burmeister's book The Professional Houseparent (*copyright 1960 by Columbia University Press*).

SALLY, SEVENTEEN, who had spent several years in a group of ten girls, was about to leave. Feeling quite mellow about the agency at this point, she made this statement: "Nowhere else would you find such a collection of characters, but you sure can gain something from each one." Sally was expressing one of the positive values in group living. The child with problems, the one who feels different, whom no one else has wanted, and who feels that he has been kicked around here, there, and everywhere, should feel, when he comes into the institution and into the group, that "this is a place where they try to help you." Something in the atmosphere, in the surroundings "speaks" to him. When staff attitudes are those of acceptance of children, of understanding those who are unusual or different, the members of the groups will reflect this, some of it at least, in their attitude toward one another. A youngster may have the feeling that he is different, that his parents are different, that what has happened to him has happened to him alone. Now he sees that others are in the same situation, and that the staff has a matter-of-fact but helpful attitude about it.

Another value in the group setting is that here is a place, here are people, and here is a daily routine that can be depended on. Children who come to institutions usually have had so little that they could count on. In this new place they can, or should, be certain of the fact that they can stay and that they will not be put out, sure of the house, the houseparents, and the routine. The house, even though it may be an ugly old brick or stone building, still looks solid and permanent. The child is reassured by the fact that when he gets up in the morning and when he comes home from school at noon and in the afternoon, there will be an adult to receive him and to look after him. Many of the children, while still in their own homes, had to be on their own at too early an age. . . . In some instances of trouble between parents—fighting, drinking, psychological strains and stresses—the child stayed away, unable to face his life at home, delaying as long as he could his return to the house after school and at supper time. A child does not like to come into a home where there is trouble, or into empty rooms. When later he comes into the place where his group is, he knows that his own or the relief houseparent will be there.

The very regularity of the routine gives security—the three good meals a day, plus snacks, one's own bed, and that the way things were done yesterday are pretty much the way they will be done today and tomorrow. These many seemingly small and minor things can be counted on absolutely, and this gives support and reassurance. The fact that the boy or girl can be sure of what will happen is important, and also that he can be sure well in advance. For this reason the cottage parent needs to do a good deal of explaining to the group, in regard to arrangements, shifts in staff duty, and changes in routine. . . . youngsters appreciate being "on the inside." They do not like to be taken unaware, to be caught off-guard, or as they might say it, to have something "put over" on them.

Coming together three times a day for meals, working side by side, observing the same rules, sharing all phases of the routine as well as playing together, makes for a growing closeness in relationships which becomes a positive group factor. In spite of differ-

ences, competitiveness, and rivalries within the group, the child usually develops a feeling of belonging with and a loyalty to these other boys or girls with whom he shares so much. The youngster, more often than not, thinks of his group positively, and with a sense of identity with it, even when he has some not-so-friendly things to say about individuals in the group, about the institution, and at times, about his houseparent. The new child coming in, who may have been hurt and rejected by the adults in his life, often turns first to the play equipment, the pets, and to the other children, and his relationships to them begin to take hold before he begins to trust a closer relationship with the cottage parent. Adolescents count heavily on one another for support. They may feel that no one understands, other than those of their own age group. It is of the utmost importance to the adolescent, in his own home or not, to have a place in a group, with others who talk his own language.

In addition to the other boys or girls, the child is exposed to a variety of possible staff relationships within the total setting. Many adults may be concerned with each child's welfare in one way or another. In addition to his cottage parents, he may have an uninterrupted hour or half hour with his caseworker each week; then there is his relief houseparent, the counselors of other groups, and the supervisor of cottage life. An adolescent girl may look across the campus with great admiration at a young male recreation worker, or the new housefather of the senior boys. Contacts may be only of a "Hi, Bill," "Hi, Jean," nature, as they meet in passing. But the friendliness of the young man, together with his respect for the girl may be quite a new experience for her. The boy or girl, in his casual or close contacts, usually finds one or two people whom he latches onto particularly.

Another of the positive values in group living is that there are many chances for each child to be given opportunities for successful accomplishments and recognition. This may be in some area of play, in learning to make his own bed, or bringing home a report card showing improvement. The houseparent, aware of the great need each child has to feel that he is good at something, makes more of the small things which he tries to do well, and gives recognition for bits of progress which might be overlooked or taken for granted in another setting.

Rules are easier for a boy or girl to take when he is a member of a group and they apply to all alike. When the new youngster comes into the group, the routines, rules, and the way things are done, are already all set and in operation, and the individual is more apt to go along with them than he would be if each situation where he needed some special permission were decided separately and individually, thus perhaps becoming a basis for disagreement between the adult and the youth. If the climate is good, with most of the members going along with the leader to a reasonable degree, then the new one coming in will take his cues from the others. He is not so likely to wage an individual war against what the others, who have been there longer, accept as reasonable.

. . . .

When there is a groupworker on the staff, he may enhance the values to the children which are inherent in the group structure by using, in a carefully planned way, situations in the daily processes of living, in order to help in the total care and treatment process. In this connection, Dorothy Kamstra, groupworker at Youth Services, Philadelphia, explains how the groupworker helps the houseparent gain "an awareness of the process within the group and some knowledge of ways to help the process be a tool for helping the individual. . . . Through the group experience in Youth Services they [the girls] have had an opportunity to learn to relate to others, to test their social skills, to find out what kind of persons they are. Any achievements they may have made in these areas did not happen by accident. We meant for it to happen through the awareness and help of the staff who use the relationships between

the girls themselves and through program as well as their own relationship to each girl."

As the positive factors in group living are considered, we find that these values are stronger when the child has chances to escape regularly from constant group living, and to be by himself for periods. Almost everyone has the desire to be alone at times, and children need this, too. This is easier to manage in the institution which has cottages, with sleeping rooms for one or two. Then a boy or girl can close a door (or slam it in anger against everyone) and have some time and a place for himself. Sometimes when such periods of being alone would be quite possible, even in a dormitory setting, this is denied the child, for two reasons in particular: 1) that certain areas are "off-limits" during the day time, most often the sleeping rooms. There are still to be found the rule that children are not permitted in their sleeping rooms at times other than bedtime; 2) that it is more difficult to supervise a scattered group than one where all of the members are together. . . . The cottage parent may be afraid that "something will happen" if one of the group, or several, are off by themselves. Too often a child is swept abruptly along with the group, and not allowed a choice as to what he wants to do, or to go to a part of the cottage or unit where he could be alone for a while. It is true that the cottage parent will need to do more circulating, particularly when a greater freedom is first permitted, but this plan has been found to be workable, giving group members the much-needed respite from the constant presence of others around them.

Individualization

Institutions have come a long way in accepting for care children who present a wide range of personality and behavior problems. In connection with intake, many groups have certainly stretched a point in giving a welcome to the "unplaceable" child. But has this willingness to make a place for the individual—no matter if his history presents every challenge in child care—been matched by an equal effort to make use of all of the possibilities for individualization within the group? For example: study hall—is it required for a definite period for *all* children in a group, including Sara, who gets very good grades and is able to do all of her preparation in school or in a short time at home, and including Al, who is so troubled about so many things that he actually just sits at a table during study hall and doesn't accomplish a thing? Bedtime—must it be the same for all members of the group, or can some go earlier, some later, depending on their ages and needs? . . .

A houseparent might say here, "Yes, but if I gave a girl permission to leave the table early she might go into the dormitory and rummage through dressers and closets and appropriate for herself some of the things she finds there. . . ." There will always be "situations" that will need to be straightened out after they happen, as a result of which it is to be hoped that something will be worked through, and that the chances that this same thing will happen again will be slightly less. We work toward the point where boys and girls can be given more and more responsibility for self-direction, but they acquire this only through practice, even if disciplinary problems and various complications come up along the way. Houseparents sometimes anticipate more difficulties than actually develop, and may tend to cling to the same arrangement and plan for everyone alike, feeling that life is easier and less complicated that way, as indeed it is for the adult, but this way is not the best plan for the individual child.

Individualization is carried out, too, in the amount of time and attention given by the group leader to each child. Some children want and need more, others less, it is never equally divided. Some children are more ready than others for closer, warmer relationships. The cottage parent feels and responds differently toward various children, and it is a good thing for the worker to think through what his relationship to each child means to the child. Even though one child

may seek and be given a good deal more attention than some of the others, this does not necessarily mean that he is a "pet" or a favorite. Someone once said that if a certain child got extra loving, attention and approval out of *the cottage parent's need* for his response, then indeed he was a "pet," but if it was done out of *the child's need*, then it is on a safe basis. The worker may, in fact, feel quite close to, and positive toward the boy or girl who is having the greatest problems and perhaps being the most wearing and difficult member of the group. The very struggle, particularly when the adult is earnestly trying to help the child, brings them closer together.

The Size of the Group

One of the most important developments in the field of child care is that the groups for whom cottage parents are expected to care have become smaller in size. But there is still a long way to go, for there are even today some groups with as many as twenty or thirty members! So much of the effectiveness of the work of cottage parents, and so much of the child's chances for a satisfactory day-by-day life, growth, and improvement, depend upon the size of the group. The values in group living may be stronger or weaker, depending on the numbers of other children with whom the individual must share the adults who take care of him.

Suppose one were to take the children in any group today and study their case histories, keeping in mind all that they have missed of normal family life and parental care, and then add to this the casework, psychological, and psychiatric diagnoses which are often available, telling what this history means in terms of all that each child needs from the staff, and from the setting. After reading a dozen such stories, the conclusion might well be that no one person could possibly do all of this for more than eight to ten children, possibly even five or six, and do it right. As has been mentioned several times elsewhere, boys and girls coming into residential care today present much more serious difficulties than was the case ten or fifteen years ago. Each individual needs more time, patience, thought, and skill, and each one drains a good deal more out of the worker. It is not humanly possible for a cottage parent to do all that needs to be done when there are too many in the group. The child care staff member is learning more and more about the need for, and the possibilities of a positive use of the group. But the job becomes frustrating to him when he cannot put his knowledge in practice, because the group is too large.

When we think of it from the point of view of the children, we know that most have suffered from parental deprivation. Each child needs *one-eighth* or more, *not one-twentieth* of the cottage parent's time and attention. Otherwise we are only again placing the child in the position of being deprived of adult care. And the housemother or housefather has to spread himself too thin, has to divide himself among too many youngsters. When the group is large, each member will continually want more concern with himself as an individual than he gets, will clamor for it, and will feel frustrated much of the time because he does not get it. He will always be placed in the position of competing with others as he brings his needs to the attention of the houseparent. Small children in large groups often develop loud, insistent, high voices in their efforts to gain attention for themselves, and the most aggressive (but not necessarily the ones who need it the most) manage to get it. The quiet, withdrawn child may give up, may recede into the background, or be overlooked and left to himself with his problems and conflicts, which only grow worse with lack of attention.

Another point in favor of reasonably small groups is that there is less of an impact both on members of the group and on the cottage parent of extreme and sometimes bizarre behavior, of emotional upheavals and outbursts, of demands, and intensity of feelings. This is wearing enough in a group of eight or ten, and a point of no return is reached when additional children are placed in a group over and above the number which would have been workable for the members in it, as well

as tolerable to the group leader. Having a smaller group assumes a willingness to participate with the child in some of the planning and carrying out of activities mentioned in the chapters on play, clothing, and a place for the child's possessions. With a smaller group there is not only more time for the child himself, but also for these things which are such an important part of his world and life. There is time for the houseparent to talk things over with individual children, rather than, as is often the case with too large a group, when he or she finds that communication is carried on in a mass directing of traffic, "Let's all get ready for bed, now," or "Hurry, it's time for school."

It is easier for a new child to be received by a small, rather than a large, group. In the larger group where the members may already be vying with one another for the attention of the cottage parent, the admission of still another child adds to this feeling of competition, and the new one is not likely to receive a warm welcome from the others. Nor is the cottage parent, already distraught by a large group, able to give the new child the extra time and attention he needs during his first days.

. . . .

Continuity of Leadership

Whether group living will offer a positive experience depends greatly not only on the quality of the leadership but also on its continuity. Much that might be positive will be diluted, upset, thrown out of gear, or completely lost when there are too-frequent changes in cottage parents. When a good houseparent has been with an agency over a reasonably long period, offering strong leadership, his group may be settled into a good climate and spirit. Individual members will be making progress. The cottage or dormitory might be looked upon with pride and relief by the director, since everything is going along as smoothly as a group ever can. Then should the cottage parent or parents change, there is always an upheaval. If the worker has been well liked and has been able to give the youngsters real security, the group will feel a sense of loss and possibly resentment over his leaving. The group might work out its feelings by making life difficult for the new worker. Then, if this person in turn leaves, the group becomes even more upset and difficult, feeling guilty over behavior which resulted in the new worker's inability to take it and to struggle through, as well as feeling uncomfortable with the sense of power that they were able to bring about the leaving. The very group which may not have offered anyone any particular concern when in the care of an experienced and well-established worker might become a "problem group" during a series of changes in leadership.

While a change in cottage parents is always difficult for a group as a group and for the individuals within it, and while everything possible should be done to keep turnover in child care staff at a minimum, still there is a small degree of comfort in the fact that, for the children experiencing this change, several other factors remain constant. That is, the place stays the same—the general framework of the agency, the program, activities, meals, and daily life do go on. And other members of the staff who are concerned with the child, the director, the caseworker, other cottage parents, represent continuity.

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OUT-OF-WEDLOCK BIRTHS

Excerpted from **The Problem of Births Out of Wedlock,** *a preliminary report prepared by the technical subcommittee of the Committee on Children and Youth of the North Carolina Conference for Social Service. We commend the committee for its thoughtfulness and recommend that the entire report be read. The conclusions offer a basis on which communities might well study their local situations.*

CONCLUSION. The facts that have been presented here are evidence that our democratic society seeks to protect and help its more unfortunate individuals, particularly its children. Witness to this is found in the widespread development of state and federal agencies whose primary function is to provide aid and special services to those who are physically, mentally, and economically less fortunate. It is of considerable interest to note that while society on the one hand seeks to protect and help the less fortunate, on the other hand, not too infrequently, it is quick to blame these persons for many of its social ills. The problem of births out of wedlock is no exception. There are many people in our society who are quick to place the blame for this problem on the mentally retarded, mentally ill, on certain racial and cultural groups, etc. This is often done in the absence of any valid proof of the relationship of the above conditions per se to the incidence of births out of wedlock.

Certain other responsible people in our society have sought refuge in a "do nothing" attitude regarding this problem. They say, "There have always been illegitimate children, and there will always be such children, so why seek answers to a problem which is apparently as natural to human beings as fingers are to the hand." It is probably true that the problem of births out of wedlock will never be completely resolved. However, in view of our continuing attempts to improve our society, it is evident that improvement has never been accomplished with a "do nothing" attitude.

Consideration should be given to the necessity for objective study and review regarding causes of births out of wedlock. It is felt that such study should properly precede concerted efforts toward widespread control measures.

There is already, however, sufficient information available to show that no single solution to this highly involved problem exists. Just as there are many causes of the problem, so there must be many different kinds of action to alleviate it.

Since the problem stems partly from poverty, effort must be made to raise the economic levels of the poorest segments of society.

Since it stems partly from the lack of high moral standards among many, the agencies that have the means—the churches, schools, and civic organizations—must work at raising these standards among our young people.

Since it results partly from the lack of wholesome recreational facilities, greater effort must be made to make the parks, playgrounds, and other facilities adequate to meet the needs of young people.

Since the problem is due partly to emotional maladjustments of certain young people, greater stress should be placed on the development and improvement of mental health clinics and related social services.

Since the problem stems partly from difficulty in enforcing laws relating to sexual misbehavior and to non-support of children, police forces and the juvenile and domestic relations courts need to be strengthened.

Since the problem results in part from broken families and inadequate parental

care of children, greater efforts are needed from private social agencies and from public welfare departments toward strengthening family life.

Since the problem results partly from mental retardation,the appropriate agencies and institutions need to be enabled to give more help and protection to people who are so afflicted.

And since the problem is due partly to ignorance, greater efforts should be directed toward educating youth for marriage and family life.

Psychologists have discovered that the threat of punishment does little to influence human behavior in a positive way, while offers of reward can do a great deal. The lesson for society in this finding is obvious. *If the problem of illegitimacy is to be dealt with successfully, all members of society must be given the right to the pursuit of marital happiness, and the young people must be persuaded through precept and example that a lifetime of marital happiness is likely to be the reward for abiding by society's mores.*

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NEWS FROM THE FIELD

Interstate Compact on Placement

On JANUARY 22, 1960, the League participated in a meeting which marked the culmination of months of work in preparation of a model "Interstate Compact on the Placement of Children," an instrument aimed at protecting children to be sent across state lines either for interim foster care or for adoption.

Senator Elisha T. Barrett, Chairman of New York State's Joint Legislative Committee on Interstate Cooperation, presented the committee's draft compact for review and suggestions to a representative group of public welfare administrators and their legal advisors, juvenile and domestic relations court judges, and representatives of the United States Children's Bureau, the American Public Welfare Association, and the Child Welfare League of America. States represented were Connecticut, Delaware, New Jersey, Michigan, Pennsylvania, Wisconsin, Maine, Vermont, New Hampshire, Massachusetts, Rhode Island and New York. Participants tested content and language, suggested some changes to overcome state differences, and heartily endorsed the compact as a forward step for protection of children in interstate placement.

As stated in the compact itself, it would become the purpose and policy of the states involved to cooperate with each other in the interstate placement of children to the end that:

Each child requiring placement shall receive the maximum opportunity to be placed in a suitable environment and with persons having appropriate qualifications and facilities to provide a necessary and desirable degree and type of care.

The appropriate authorities in a state where a child is to be placed may have full opportunity to ascertain the circumstances of the proposed placement, thereby promoting full compliance with applicable requirements for the protection of the child.

The proper authorities of the state from which the placement is made may obtain the most complete information on the basis of which to evaluate a projected placement before it is made.

Appropriate jurisdictional arrangements for the care of children will be promoted.

Interstate compacts have been employed with increasing success in recent years as a method for setting up reciprocity procedures among states. In the fields of health and welfare, the uniform Reciprocal Enforcement of Support Act, the Interstate Compact on Juveniles, and the Interstate Mental Health Compact all have contributed to social and health provisions for families and children who otherwise would have been disadvantaged because they had crossed state lines. Therefore, the just completed Interstate Compact on Placement of Children adds one

more carefully written compact by which state legislatures may act to protect children.

Among the advantages for children which will be promoted when states have enacted this compact are:

Better planning in advance of placement of children in a "family free or boarding home or in a child caring agency or institution," including a determination of the reasons for the proposed placement and evidence of the authority for making the placement.

Better assurance of continuing responsibility for service and financial support on the part of the placing agency and the sending state, but with provision for such service and financial support in the receiving state as the receiving state provides its resident children in the event the placement agreement as originally made breaks down.

More extensive protection to more children through application of the compact to courts, voluntary agencies, and public administrative agencies.

Better coordinated inter-agency services in behalf of children: intrastate as well as interstate, voluntary with voluntary, court public with administrative public, and public with voluntary.

Senator Barrett concluded the meeting with two strong points:

1. The compact will be introduced immediately into the New York State legislature for enactment. Its passage will enable public agencies in New York for the first time to place a child, and finance the cost of his care and treatment, in an agency in another state when this is in the child's best interest.

2. Success in protecting children in interstate placement depends upon passage of the compact in each and every state. The participants in this meeting have a particular responsibility to give it their support in their respective states and agencies.

The Child Welfare League of America subscribes to the principles contained in this compact. Its study and support are the responsibility of League member agencies.

EDNA HUGHES
Field Consultant, CWLA

New League Staff

Miss Janice Bowen will rejoin the League's staff as Director of Surveys in the near future. She was a consultant for the League from 1953–1957 after which she returned to her former position of Executive Director of the Child and Family Service, Portland, Maine, where she has been developing a research department in addition to her administrative responsibilities. Miss Bowen had extensive experience in casework, supervision and administration in Hawaii before going to Portland in 1941. She is a graduate of the School of Applied Sciences, Western Reserve University. Miss Bowen has directed innumerable surveys both for the League and independently.

Miss Mildred K. Wagle will join the League's staff as Field Service Coordinator in the near future. This is a new position and will encompass the field service responsibilities formerly assigned to Miss Hagan, Assistant Executive Director.

Miss Wagle is a graduate of the School of Social Work of the University of Pittsburgh. Her experience includes supervision of an agency with a large foster home and adoption program; casework, supervision and administration in several family and children's agencies; field consultation for The Family Service Association of America; consultation on general program and welfare, Association of Junior Leagues of America, Inc. She was also director and coordinator of United Community Defense Services and Family Service Association of America programs for FSAA; Executive Director of the Family and Children's Service of Lancaster County, Pennsylvania, and most recently Associate Director of Task Force on Community Resources, Joint Commission on Mental Illness and Health. Miss Wagle is co-author with Dr. Reginald Robinson and Dr. David F. DeMarche of the book *Community Resources in Mental Health*, published by Basic Books in 1959.

PRESENT PLEASURE

Present Pleasure, the foster family care play by Nora Stirling, is being warmly received in performances throughout the country.

The Broadway cast is performing the play in New York and nearby states with results from potential foster parents and those already recruited; for instance, this excerpt from Windham Children's Service of New York:

"The play was performed last night for our Board, staff and foster parents and it was a tremendous success. About two hundred people attended and the response was wonderful—several times, there was applause during the performance—and the discussion at the end was the best we've ever had. The audience laughed, cried, loved the play! So did the Board and staff."

Vernon Daniels of the Protestant Federation of New York said:

"When two hundred prospective foster parents met at the Baptist Church to see the play we had an enthusiastic response. They were particularly moved by the little boy and the social worker, whose part in the play showed her role in helping foster parents over the rough spots."

Mrs. Henrietta L. Gordon reports that 371 copies of the play have already been sold. When she was in Montreal, where ***Present Pleasure*** was performed by local players, they said that the play has been making many an annual meeting lively and different and Chest meetings more meaningful.

You will find ***Present Pleasure*** has three important values:

1. Recruiting new foster parents.
2. Deepening insight for current parents.
3. Helping boards and communities understand the considerable expenditure of professional time, skill and money needed for foster care.

And it does provide a half-hour of engaging drama without need of props or scenery.

A single copy of the script is $2.00; a performing kit of five copies is $10. (The latter fee is required for the right to perform the play locally.)

If Plays for Living can help you find local players or help in any other way, write them at 215 Park Ave. South, New York 3, N. Y.

READERS' FORUM

*Broad Community Approach To Day Care**

To the Editor:

What a wonderfully creative way to use staff, money and community resources! Those are my immediate reactions on reading Mr. Host's paper. Frequently, taking what comfort we can in the fact that we are working at top capacity, we tend to hedge ourselves into corners of endeavor, and forget to look beyond our own resources. Under such circumstances would we dare to initiate a relationship between a social agency and commercially operated programs? To many this would be heresy. Yet Mr. Host tells us how a well-established day care agency has done this in Houston, and how a better climate has consequently been created in that city for understanding day care services.

There are many interrelated concepts in Mr. Host's article that I want to comment about. Many people might raise the question as to whether such a program gives encouragement to the many commercially operated day care programs. I believe that it will encourage some of the more able programs to raise standards. Best of all, it opens a way for them to obtain some casework insights for themselves and also, we would hope, for the parents using the programs.

I agree with Mr. Host that the majority of the owners of commercial homes and centers are interested in providing good day care and that they welcome help in improving their service. In Tennessee we have had this demonstrated again and again as owners have traveled great distances to attend workshops. A reality frequently forgotten about a commercial facility is that it too has a budget and can provide only the level of service that the parent is both able and willing to pay for. We know of few programs in Tennessee where the operator gets much financial return. Rather, we have found that people run these programs because they en-

* *Ed. Note:* We invite further discussion of this subject, which was originally presented in the February issue.

joy working with young children and, in the majority of cases, also with their very young parents. Because of the mobility of our present population, and perhaps because so many of these young families live far from their own parents, the day care operator can and frequently does step into a grandmother role. To our way of thinking she is an important individual. And to me it is gratifying that in Houston some are receiving assistance in becoming better grandmother figures.

I think that social workers frequently overlook one of the strengths of day care service: that it cares for children where the family is still intact, regardless of the complexity of the problems. In addition, the parent usually wants to and frequently should carry his parental responsibilities. He may need help in doing this regardless of his financial ability, and at times we have to reach out to him if either he or the child is to benefit before it is too late. Lois Ryder, in writing of the experience of Summit County, Ohio, in licensing independent boarding homes, has said much this same thing.[1] In Summit County they found that many parents using independent boarding homes resisted casework help, but after they understood the nature of the service were able to use it purposefully to make better plans for their children.

Let's hope that the day care operators in Houston become skillful in making referrals, and that they help the agency to reach out to some of these parents. I agree with Mr. Host that the need for casework services to parents and children using day care services varies. Therefore the operator needs assistance in evaluating the seriousness of different family situations. If she herself has had some experiences with the warmth and understanding of a caseworker's insight, then the referral that is made develops a background of sincerity and friendliness that otherwise would not be possible. Probably each one of these day care programs has a few children through agency referrals, but we must remember that many children are placed in day care services, wisely or unwisely, directly by their parents. I believe that this plan opens an avenue for obtaining professional help in selected cases.

I do have some questions about details of the Houston plan, but perhaps they are not valid since these procedures are a relatively new development and the policies seem not to be final. I wonder about the criteria over and above the minimum state licensing requirements used to evaluate the various programs. Were the operators informed of these criteria so that they knew the grounds on which judgments were made or did they remain secret and unknown, something to be speculated about? In Tennessee it would not be possible for the state department to share evaluations, as we consider such material to belong only to the programs licensed. In addition, it seems fair to state that, in Tennessee, some programs which are not supported by United Funds—privately operated or other programs—can and do maintain higher standards than those supported through these means. As mentioned earlier, the amount of money in the budget and the desire to do a good job are both important.

And perhaps it is because I have such deep convictions about day care being used to strengthen parent-child relationships that it bothers me that the caseworker rather than the parent decides where the child is placed. I wish that the social worker, after giving the parent some pointers about what to look for, would suggest two or three cooperating homes or centers to visit and then encourage the parent to make the final decision. This could be done if the amount of subsidy that the agency pays for a fee is fixed before the visits. This, I believe, would be the preferred procedure.

I think all of us working in day care services can be grateful that the Houston Day Care Association decided to meet the problem of increased need not by closing intake, but by embarking on this pioneering venture. The procedures that are outlined deserve thoughtful consideration by many, although I would hate to see any except a well qualified agency undertake such an enterprise.

LUCILE LEWIS
Senior Day Care Consultant
Tennessee Dept. of Public Welfare, Nashville

[1] Lois Ryder, "A New Concept of Independent Boarding," CHILD WELFARE, June 1958.

BOOK NOTES

The Child with a Handicap: A Team Approach to his Care and Guidance, Edited by Edgar E. Martmer, M.D.,* Springfield, Ill.: Charles C Thomas, 409 pp., $11.00.

This is a symposium on handicapped children with emphasis on various types of handicaps and disabilities and the role of the physician, parent, psychiatrist, social worker and teacher in their care and education. Specific chapters are devoted to the role of each of these professions, and fifteen chapters are concerned with specific diseases and conditions, such as congenital heart defect, rheumatic fever, muscular dystrophy and mongolism.

The first chapter, "The Role of the Physician," was written by Samuel M. Wishik, M.D., M.P.H., Chief of the Department of Maternal and Child Health, Graduate School of Public Health, University of Pittsburgh. This and a chapter called "Guides for Parents," by Elizabeth M. Boggs, Ph.D., President, National Association for Retarded Children, Inc., would alone justify the purchase of the book, in my opinion.

Indeed, the number of first-rate chapters is above the average for symposia of this kind, which all too often suffer from a regrettable unevenness in technical competence and writing ability. Another difficulty that arises in the writing and editing of a work of this kind is that of striking a balance between breadth and depth. To some extent one must be sacrificed in favor of the other. The editor of this volume, however, has compensated well and wisely for an understandable lack of depth by the inclusion of excellent bibliographies after each chapter and "Guides to Reading Materials" at the end of the volume. Another section, "Additional Books on Handicapping Conditions and Rehabilitation," which contains an annotated list of more than one hundred titles, is also of great value to the student and the child welfare worker who wish to delve more deeply into not only the physical, but the more subtle and deeper, nature and implications of chronic illness and disability.

A great deal has been accomplished in the last decade in improving the techniques of surgery, bracing, medication, and medical management of the handicapped, and in the education, vocational guidance and employment of disabled children and youth. There remains, however, the almost unexplored area of the inner life of the handicapped person, and his home and school relations, all of which cry out for penetrating research and understanding. Chapters one and twenty-four, referred to earlier, provide some insight into these aspects: Chapter one from the point of view of a wise and sensitive pediatrician, and Chapter twenty-four from the point of view of a parent who knows what it means to bear and rear a disabled child.

In a book like this, the title and even the chapter headings are significant; for example "The Child with a Rheumatic Heart Condition" is preferable, by far, to "The Child who is a Mongol."

This volume can be recommended without reservation to child welfare workers who feel the need not only for further information and orientation but for a deeper insight into the triumphs and tragedies, the successes and failures, of those who live with and seek to conquer a handicap.

LEONARD W. MAYO
Executive Director,
Association for the Aid of Crippled Children, NYC

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Education and Health of the Partially Seeing Child, Fourth Edition, by Winifred Hathaway. Revised by Franklin M. Foote, M.D., Dorothy Bryan and Helen Gibbons. New York: Columbia University Press, for the National Society for the Prevention of Blindness, Inc. 201 pp., $5.00.

Just as school personnel should know about community resources for children, so social workers for children should know about educational plans and facilities for them. This book is a welcome addition to the social agency library.

* Past President American Academy of Pediatrics, Associate Clinical Professor of Pediatrics, Wayne State University College of Medicine.

AN AUTHOR'S COMMENTS

In the January issue of CHILD WELFARE, Lorena Scherer reviewed my book, *Child Welfare: Principles and Methods*. She stated that: "There have been a few years of growth in the field of adoption and foster care, particularly, since the book was written, and the reader is not brought up to date on present philosophy that foster care should not become a way of life for children."

Miss Scherer has since written to me as follows:

"Perhaps this was a hurried statement on my part. Because, by the very nature of your research you emphasized the importance of the family to the child. I had specific reference to the fact that you could not have included in your book, or brought up to date, Maas's preliminary reports of the Child Welfare League's two-year study of children in foster care, because this material was not available to you when you went to press. Further, there have also been additional articles published and studies made that point to the need for adoptive care of the child who cannot be returned to his own home, since you went to press."

I appreciate Miss Scherer's fairness in making these explanations. I am grateful, too, for her comment that she and several professors at two schools of social work regard my book as "the best contribution to the history of child welfare since Thurston."

May I say that I point out the necessity of returning a child to his own home as soon as possible on pages 342, 343, 349, 350, 351, 358, 366 and 370.

DOROTHY ZIETZ
Associate Professor of Social Welfare
Sacramento State College, Sacramento, Calif.

CLASSIFIED PERSONNEL OPENINGS

Classified personnel advertisements are inserted at the rate of 15 cents per word; boxed ads $7.50 per inch; minimum insertion $3.00. Deadline for acceptance or cancellation of ads is eighth of month preceding month of publication. Ads listing box numbers or otherwise not identifying the agency are accepted only when accompanied by statement that person currently holding the job knows ad is being placed.

LOS ANGELES—Openings for two caseworkers with graduate training in expanding family and child welfare agency—multiple services including marital counseling, unmarried parents, financial assistance, child placement in foster home care and group care, psychiatric consultation. Highly qualified supervision. Standard personnel practices. Opportunities for advancement. Salary, $4836–$6656 depending on training and experience. Write: Rev. William J. Barry, Assistant Director,Catholic Welfare Bureau, 855 S. Figueroa St., Los Angeles 17, Calif.

CASEWORKER (MSW)—Progressive child-caring agency offers opportunities to work in group care and foster care. Total population 34. Boys and girls from 10 years old through high school, of normal intelligence with emotional problems. Psychiatric consultation available. Good personnel practices. Will consider beginner. Salary range $5400-$7000. Starting salary dependent on qualifications. Write to R. B. Matthews, Superintendent, Adelaide Christian Home for Children, 5441 Overland Ave., Culver City, Calif.

CASEWORK SUPERVISOR: The Adoption Institute has an immediate opening for a top-notch person with MSW and qualifying experience. Good salary, fringe benefits and challenging work situation. Write: Ben Hoffman, Executive Director, 1026 S. Spaulding Ave., Los Angeles 19, Calif.

CASEWORKER, female, M.S.W. Treatment oriented children's home. Good supervision, psychiatric consultation. Small case load. Starting salary $5400. Frank Howard, Episcopal Church Home For Children, 940 Ave. 64, Los Angeles 42, Calif.

CASEWORKER II or III—MSW—(Male). In parent-child guidance service. Casework treatment oriented toward work with total family of boys aged 6–18. Work is challenging and stimulating. Minimal dictation with supervision geared toward independent practice. CWLA member. Psychiatric and psychological consultation available. Social Security and retirement, health insurance. Effective March1—Salary: II,$5400–6756; III, $6036–$7548; 5-step plan. Can appoint at qualified step. Milton L. Goldberg, Executive Director, Jewish Big Brothers Association, Room 366, 590 N. Vermont Ave., Los Angeles 4, Calif.

CHILD WELFARE SERVICES WORKER. Approximately $460–$507 per month. Immediate openings in adoptions, child placement and protective services for social workers with 1 year grad. social work. No experience necessary. High professional standards and advancement opportunities. Write County Personnel, 403 Civic Center, San Diego 1, Calif.

EXECUTIVE DIRECTOR—Are you interested in a new dynamic program, working with pre-school children? Would you like the opportunity to develop a new therapeutic program for children, plan a new building around the service, recruit staff, and generally pioneer a demonstration project? Such an opportunity is available in Los Angeles as the executive director of a therapeutic nursery for pre-school children, 3–5 years of age. The service will be hospital oriented, and child centered with the best medical and psychiatric services available to both children and parents in the treatment process. We are looking for an agency executive for this program with specific experience in working with emotionally disturbed children, in both a teaching and casework relationship. A five-step salary range, from $665–$831 per month, is established. Beginning salary will depend on qualifications of applicant. Liberal fringe benefits are attached to the job. Write Alfred A. Shapiro, 590 N. Vermont, Los Angeles 4, Calif.

CASEWORKERS: The Adoption Institute has several immediate openings for mature, flexible, competent persons with MSW, with or without experience in a child or family welfare agency. Salary related to applicant's qualifications. Fringe benefits and challenging work situation. Write: Ben Hoffman, Executive Director, 1026 S. Spaulding Ave., Los Angeles 19, Calif.

SOUTHERN CALIFORNIA
Opportunities

If you are interested in employment as a caseworker in a family, child welfare, or adoption agency under Catholic auspices, read this carefully—Mr. William Erickson, representing several Catholic agencies in the family and child welfare fields, will be interviewing and accepting applications for excellent employment opportunities in Southern California. He will be representing agencies in the Greater Los Angeles Area and in the Counties of Santa Barbara, Ventura, Orange and San Bernardino.

You may contact him for an interview by calling the hotels listed on the dates indicated (between 5:00 P.M. and 8:30 P.M.). Leave your name and phone number if you do not make contact. If you wish to make contact before the date listed, write to the agency of your choice or directly to Mr. William Erickson, Catholic Welfare Bureau, 855 S. Figueroa St., Los Angeles.

St. Louis, Mo.—March 20 and 21—Pick-Melbourne Hotel.
Chicago, Ill.—March 23—Palmer House.
Boston, Mass.—March 25—Sheraton Hotel.
Washington, D. C.—March 28 and 29—Manger Hamilton Hotel.
New York City—April 4—Commodore Hotel.

CHILD WELFARE SERVICES WORKER and SUPERVISOR POSITIONS for fast growing county in southern California. Opportunities in adoption included. WORKER I ($5130–$6084) requires 1 year's graduate study in social work. WORKER II ($5388–$6384) requires 1 year's graduate study in social work and 2 years' experience or 2 years' graduate study. SUPERVISOR ($5940–$7044), requires 2 years' graduate study and 2 years' experience, 1 of which must be in child welfare. Paid vacation and sick leave, part-paid health insurance, other benefits. County Personnel, Courthouse, San Bernardino, Calif.

CASEWORKER in diversified and dynamic children's program. Rapid advancement possible. All benefits in fabulously growing Denver. Write Dr. Alfred M. Neumann, Jewish Family & Children's Service, 314—14th St., Denver 2, Colo.

CASEWORKERS in a progressive Catholic multiple-function agency serving Catholic families and individuals. Supervisory opportunities for experienced workers if so interested. Agency offers counseling services for family and marital problems, casework with unwed mothers, child placement and adoption services. Member agency of the Child Welfare League of America and the Family Service Association of America. In-service training program and individual and group psychiatric consultation. Agency currently affiliated with 2 schools of social work. Social Security and retirement. Master's degree in social work required. Salaries in $4800–$7000 range, based on qualifications. Edward J. Power, Executive Secretary, The Diocesan Bureau of Social Service—Archdiocese of Hartford, 244 Main St., Hartford 3, Conn.

CASEWORKER in family and children's agency providing family casework, child welfare services, foster home placement, and adoption. Good personnel practices. Requirements: MSW. Salary $4620–$5820. Social Security and retirement. Rev. John J. Reilley, Associate Director, Diocesan Bureau of Social Service, 259 Main St., New Britain, Conn.

SUPERVISOR OF CASEWORK: Family and Child Care Agency—Qualifications include professional education and experience in casework practice and supervision of qualified staff with psychiatric consultation. Agency functions: family casework, foster care of children, service to unwed parents and adoption. The responsibilities include directing casework services and student program with related community and administrative activities. Salary commensurate with good practice and current standards. Social Security and retirement benefits. For further details of position write: Miss Jane K. Dewell, District Secretary, The Diocesan Bureau of Social Service, 478 Orange St., New Haven 2, Conn.

SOCIAL GROUP WORKERS: Male and female. For therapeutically designed group homes, each serving 8 adolescents who are able to use community schools and facilities. Develop group program in collaboration with treatment team. Program scheduled to open summer, 1960. Required: MSW and experience with adolescents. Salary: open, depending on qualifications and experience. Lois Wildy, Executive Director, Illinois Children's Home and Aid Society, 1122 N. Dearborn St., Chicago 10, Ill.

FIELD REPRESENTATIVE in child welfare services in State Department of Public Welfare. Under Chief, Bureau of Social Services, responsible for developing standards, policies and procedures, consult with county supervisors and other personnel; review and prepare reports on county operations; plan and execute staff development programs. Four weeks' vacation, liberal sick leave, car furnished when required. Required: MSW or 2 years' experience as executive, supervisor or consultant in public child welfare agency may be substituted for 1 year of graduate training; 5 years' professional employment in a welfare agency including 3 years in a supervisory, administrative or consultant capacity in public child welfare agency. $6190–$8050. Can appoint at $6934. Good state retirement plan integrated with Social Security. Miss E. Kathryn Pennypacker, Chief, Bureau of Social Services, State Department of Public Welfare, P. O. Box 309, Wilmington 99, Del.

CASEWORKER with master's degree. Nonsectarian institution centrally located in Chicago serving boys 10 through 17 years of age. Employment during late afternoon and early evening hours. Salary $5400 plus. W.J. Grenier, Executive Director, Lawrence Hall, Inc., 4833 N. Francisco Ave., Chicago 25, Ill.

CASEWORKER, Male. Well-established residential treatment center, capacity 22 children, 6–12. Excellent supervision for workers who wish to learn child therapy. Highly experienced child analyst consultant, Dr. Harold Balikov, teaching child-care course at Chicago Institute for Psychoanalysis. Program now under review by professional advisory committee with prospects for interesting new developments ahead. Beautiful setting in suburban community. Salary open. F. R. King, Ridge Farm, 40 E. Old Mill Rd., Lake Forest, Ill.

REGIONAL CHILD WELFARE SUPERVISOR II. State program of child welfare services (CWLA member) in 17 county area surrounding Peoria, Illinois. Supervision of professional staff of 25. Interpretation of program and planning with communities for sound child welfare programs. Required: MSW, 4 years' child welfare including 2 years' experience as supervisor. Range $6000–$7400. Can appoint above minimum. Roman L. Haremski, Superintendent, Child Welfare Services, Illinois Department of Public Welfare, 401 S. Spring St., Springfield.